DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G161	A. BUILDING _____ B. WING _____	R 06/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRYSALLIS	3765 FIRST STREET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS A follow-up was conducted on 6/16/2008 to assess the facility ' s level of compliance with the Re-Certification survey completed on May 2, 2008. A random sample of three clients was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews with the facility staff and a review of records, including unusual incident reports. The findings of the revisit revealed the facility still had not met the standards for full compliance with the Conditions of Participation in Governing Body, Client Protections, and Facility Staffing.	{W 000}	Received 8/21/07 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
{W 114}	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each entry into a client's record was signed and dated, for one of three clients (Client #1) included in the sample. The finding includes: The facility was previously cited during the 5/2/2008 survey for failing to ensure that its medical staff/consultants signed and dated each entry that was made into a client ' s medical record. The example provided was based off of Client #1's April 2008 Physician's Orders (POS). The citation reflected that an order for Erythromycin Ophthalmology 5mg/gm ointment which was to be applied to each eye every	{W 114}	As answer to W 114, the facility says as follows: The facility has made a new policy and created a new Quality Enhancement Review Tool to facilitate detection and correction of any wrong entry in the medical book of all the residents of the facility. The quality enhancement review form and the new policy are attached.	8/18/08 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Steve J. Wilson, President/CEO | 8-20-2008 revision

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000}	INITIAL COMMENTS A follow-up was conducted on 6/16/2008 to assess the facility ' s level of compliance with the Re-Certification survey completed on May 2, 2008. A random sample of three clients was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews with the facility staff and a review of records, including unusual incident reports. The findings of the revisit revealed the facility still had not met the standards for full compliance with the Conditions of Participation in Governing Body, Client Protections, and Facility Staffing.	{W 000}	**GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002**	
{W 114}	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each entry into a client's record was signed and dated, for one of three clients (Client #1) included in the sample. The finding includes: The facility was previously cited during the 5/2/2008 survey for failing to ensure that its medical staff/consultants signed and dated each entry that was made into a client ' s medical record. The example provided was based off of Client #1's April 2008 Physician's Orders (POS). The citation reflected that an order for Erythromycin Ophthalmology 5mg/gm ointment which was to be applied to each eye every	{W 114}	As answer to W 114, the facility says as follows: The facility has made a new policy and created a new Quality Enhancement Review Tool to facilitate detection and correction of any wrong entry in the medical book of all the residents of the facility. The quality enhancement review form and the new policy are attached.	8/18/08 ongoing

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{W 114}	Continued From page 1	{W 114}		

evening was discontinued and there was no corresponding signature or date to validate that order.

The facility ' s plan of correction detailed that by 6/10/2008 this deficient practice would be addressed by the following action(s):

" The nurse had been instructed to review all physician orders for proper signature and dating. The MD must sign and date every notation that the MD makes on the physician orders and in the medical records. The DON will more aggressively monitor entries in clients' records to ensure consistent compliance with recording procedures. "

On 6/16/2008, record review revealed a hand written order for Debrox 6.5% solution was entered into Client #3 ' s medical records in May 2008, but it was neither signed nor dated. In addition, it was not clear who ordered this new medication. Further record review revealed, a corresponding order to discontinue Aurodex ear treatment was found in the 3/2008 Physician Order Sheets. According to the QMRP as interviewed on 6/16/2008, the Aurodex was discontinued and was to be replaced by the Debrox 6.5% solution. From the records presented on the evening of 6/16/2008, it was unclear when each medication started or was stopped. It was also unclear who ordered/validated that these medications were to be exchanged and/or initiated for treatment as the signatures and dates were missing. The facility failed to ensure an effective system to address the consistent signing and dating of entries into a client ' s medical records as previously cited on 5/2/2008.

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{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the three clients (Clients #1 and #2) included in the sample. The finding includes: The facility was previously cited for failing to ensure client ' s guardians were informed of pharmacological sedations, and for failing to obtain informed consent prior to initiating a psychotropic medication regimen. The facility presented in their plan of correction that by 6/18/2008 they would create and implement an " informed consent " form to address this systemic void. On 6/16/2008 at 5:12pm, the facility ' s Qualified Mental Retardation Professional indicated the form had been created and that the facility plans on using it going forward. Record review revealed there was no evidence on file or presented at the time of survey to substantiate that such a form was created. This lack of evidence presents that the	{W 124}	The facility has new consent forms for psychotropic medication and treatment for the residents of the facility. The two forms are attached. The DON and QMRP will coordinate the process and ensure that all needed consent is obtained for the use of psychotropic medication and treatment.	6/16/08 ongoing

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{W 124}	Continued From page 3 facility failed to ensure an effective system to address client safety as previously cited on the 5/2/2008 recertification survey and as presented on their plan of correction.	{W 124}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure accurate record keeping. [See W114] 2. The QMRP failed to ensure the implementation and review of systems that ensure client health and safety. [See #124] 3. The QMRP failed to ensure the coordination of services to ensure the health and well-being of the facility ' s residents. [See W322, W331]	{W 159}	As response to W 159, the facility says as follows: 1. The QMRP shall review the medical and other books of record at least every two months and share the outcome of such reviews with the DON and CEO for any needed correction within three days of such reviews. 2. The QMRP shall follow up with corrective actions within 5 days of the review.	8/18/08 ongoing
{W 322}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by:	{W 322}		

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{W 322}	Continued From page 4 Based on interview and record review, the facility failed to ensure general and preventative care services, for two of the three clients (Clients #1 and #2) included in the sample. The findings include: The facility was previously cited during the 5/2/2008 recertification survey for failing to ensure Client #1 received the prescribed stool tests as directed by the client's Primary Care Physician (PCP); for failing to ensure Client #1 received his antibiotic treatment in a timely manner; and for failure to ensure Client #1 received his treatment of Erythromycin Ointment in a timely manner. The facility ' s plan of correction detailed that by 6/4/2008, the facility ' s medical staff would be trained to address the above citations. Interview and record review with the facility ' s Qualified Mental Retardation Professional on 6/16/2008 at 6:05pm revealed the evidence of training was not available at the home during the time of the revisit. In addition, the QMRP indicated, all evidence of the trainings was with the Director of Nursing and not in his possession. There was no evidence on file or presented at the time of survey to substantiate that an effective system or staff training had been implemented to address the citations levied during the recertification survey on 5/2/2008.	{W 322}	1. Nursing shall inform the PCP within 3 days after unsuccessful attempts at collecting bodily fluids or stool specimens for test that the physician has ordered. The physician shall address attempts in a timely manner as he /she deems medially appropriate (i.e. alternative method of collection, obtaining specimen himself in office, or, determining the continued need for the test.) 2. The medication nurses have been instructed to ensure that client #1 and other residents of the facility receive their ointments and other medications in a timely manner as ordered by the prescribing physician. 3. The DON and the QMRP will henceforth more aggressively monitor the administration of all topical ointments and other medications to ensure consistent compliance with order.	6/18/08 6/13/08 ongoing
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure that	{W 331}		

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{W 331}	Continued From page 5 each client received nursing services in accordance with their needs, for four of the six clients (Clients #1) that resided in the facility. The findings include: The facility was previously cited during the 5/2/2008 recertification survey for failing to provide a client with sunscreen lotion as presented in their habilitation plan; failing to ensure its nursing personnel administered/monitored each client ' s treatments; and for failing to ensure the implementation of an effective system for documenting discontinued medications and treatment. The facility ' s plan of correction presented that by 6/13/2008 all staff working with Client #1 would be instructed to consistently apply sunscreen on Client #1 whenever he was going outside during the day. In addition, staff would be retrained on the use of sunscreen for this client. Record review revealed there was no evidence on file or presented at the time of survey to substantiate that this deficient practice had been addressed. Interview with the facility ' s Qualified Mental Retardation Professional on 6/16/2008 at 6:29pm revealed the evidence of training was not on file in the home, but was being kept by the Director of Nursing. The lack of evidence presented during the revisit reflects that the facility had failed to implement an effective system of oversight and care to ensure the health and safety of its residents. [Cross Reference W114, W322]	{W 331}	1. The staff has been applying the sunscreen as instructed by the nurse. 2. Additional staffing training on sunscreen application was done on 6/16/08 A copy of the training signing sheet is attached. 3. Nursing and the QMRP will more aggressively monitor staff application of the sunscreen and other needed applications.	6/16/08 ongoing

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{I 000}	INITIAL COMMENTS A follow-up was conducted on 6/16/2008 to assess the facility ' s level of compliance with the Re-Certification survey completed on May 2, 2008. A random sample of three residents was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews with the facility staff and a review of records, including unusual incident reports. The findings of the revisit revealed the facility still has not met the standards for full compliance with the Conditions of Participation in Governing Body, Resident Protections, and Facility Staffing.	{I 000}		
{I 180}	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans. The finding includes: The facility failed to ensure that its Qualified Mental Retardation Professional (QMRP) adequately monitored, integrated, and coordinated each resident's active treatment program. [See Federal Deficiency Report Citation W159]	{I 180}	As response to 1180, the facility says as follows: 1. The QMRP shall review the medical and other books of record at least every two months and share the outcome of such reviews with the DON and CEO for any needed correction within three days of such reviews. 2. The QMRP shall follow up with corrective actions within 5 days.	8/18/08 ongoing

Health Regulation Administration

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{I 291}	Continued From page 1	{I 291}		
{I 291}	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each entry into a resident's record was signed and dated, for one of three residents (Resident #1) included in the sample. The finding includes: The facility was previously cited during the 5/2/2008 survey for failing to ensure that its medical staff/consultants signed and dated each entry that was made into a resident ' s medical record. The example provided was based off of Resident #1's April 2008 Physician's Orders (POS). The citation reflected that an order for Erythromycin Ophthalmology 5mg/gm ointment which was to be applied to each eye every evening was discontinued and there was no corresponding signature or date to validate that order. The facility ' s plan of correction detailed that by 6/10/2008 this deficient practice would be addressed by the following action(s): " The nurse has been instructed to review all physician orders for proper signature and dating. The MD must sign and date every notation that the MD makes on the physician orders and in the medical records. The DON will more aggressively monitor entries in residents' records to ensure consistent compliance with recording procedures. " On 6/16/2008, record review revealed a hand	{I 291}		

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{I 291}	Continued From page 2 written order for Debrox 6.5% solution was entered into Resident #3 ' s medical records in May 2008, but it was neither signed nor dated. In addition, it is not clear who ordered this new medication. Further record review revealed, a corresponding order to discontinue Aurodex ear treatment was found in the 3/2008 Physician Order Sheets. According to the QMRP as interviewed on 6/16/2008, the Aurodex was discontinued and was to be replaced by the Debrox 6.5% solution. From the records presented on the evening of 6/16/2008, it is unclear when each medication started or was stopped. It is also unclear who ordered/validated that these medications were to be exchanged and/or initiated for treatment as the signatures and dates were missing. The facility failed to ensure an effective system to address the consistent signing and dating of entries into a resident ' s medical records as previously cited on 5/2/2008. [See Federal Deficiency report citation W114]	{I 291}	As answer to 1291, the facility says as follows: The facility has made a new policy and created a new Quality Enhancement Review Tool to facilitate detection and correction of any wrong entry in the medical book of all the residents of the facility. The quality enhancement review form and the new policy are attached.	8/18/08 ongoing
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services, for one of the three residents (Residents #1) included in the sample. The findings include:	{I 401}		

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{I 401}	Continued From page 3 The facility was previously cited during the 5/2/2008 recertification survey for failing to ensure Client #1 received the prescribed stool tests as directed by the client's Primary Care Physician (PCP); for failing to ensure Client #1 received his antibiotic treatment in a timely manner; and for failure to ensure Client #1 received his treatment of Erythromycin Ointment in a timely manner. The facility ' s plan of correction detailed that by 6/4/2008, the facility ' s medical staff would be trained to address the above citations. Interview and record review with the facility ' s Qualified Mental Retardation Professional on 6/16/2008 at 6:05pm revealed the evidence of training was not available at the home during the time of the revisit. In addition, the QMRP indicated, all evidence of the trainings was with the Director of Nursing and not in his possession. There was no evidence on file or presented at the time of survey to substantiate that an effective system or staff training had been implemented to address the citations levied during the recertification survey on 5/2/2008. [See Federal Deficiency report citations W322]	{I 401}	1. Nursing shall inform the PCP within 3 days after unsuccessful attempts at collecting bodily fluids or stool specimens for test that the physician has ordered. The physician shall address attempts in a timely manner as he /she deems medially appropriate (i.e. alternative method of collection, obtaining specimen himself in office, or, determining the continued need for the test.)	6/18/08
			2. The medication nurses have been instructed to ensure that client #1 and other residents of the facility receive their ointments and other medications in a timely manner as ordered by the prescribing physician.	6/13/08
			3. The DON and the QMRP will henceforth more aggressively monitor the administration of all topical ointments and other medications to ensure consistent compliance with order.	ongoing
{I 500}	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each client's rights.	{I 500}		

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{I 500}	Continued From page 4 The findings include: [See Federal Deficiency Report Citations W124]	{I 500}	The facility has new consent forms for psychotropic medication and treatment for the residents of the facility. The two forms are attached. The DON and QMRP will coordinate the process and ensure that all needed consent is obtained for the use of psychotropic medication and treatment.	6/16/08 ongoing